

VU Research Portal

Improving performance and responsiveness of maternal health services through social accountability mechanisms in the Democratic Republic of the Congo

Mafuta Musalu, E.

2017

document version

Publisher's PDF, also known as Version of record

[Link to publication in VU Research Portal](#)

citation for published version (APA)

Mafuta Musalu, E. (2017). *Improving performance and responsiveness of maternal health services through social accountability mechanisms in the Democratic Republic of the Congo: Strengthening the interface role in community participation*. [PhD-Thesis - Research and graduation internal, Vrije Universiteit Amsterdam].

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

E-mail address:

vuresearchportal.ub@vu.nl

Summary



Introduction

The Democratic Republic of the Congo (DRC), a post-conflict and fragile state in Central Africa, is confronting high maternal mortality. Strategies to reduce maternal mortality emphasize the increased use of maternal health services. Social accountability mechanisms are currently being promoted as an additional strategy for improving health service responsiveness, in order to encourage maternal health service use despite little evidence of its effectiveness. The research for this thesis was carried out with the objective to gain insights into whether and how social accountability mechanisms increase the responsiveness and performance of maternal health services in DRC in order to contribute to policy-making involving social accountability in maternal health.

This study was initiated to answer the following main research question:

How can social accountability mechanisms increase maternal health services responsiveness and performance?

To study social accountability in maternal health services, the social accountability framework provided by Baez-Camargo and Jacobs was used. In this framework, social accountability is described as a set of mechanisms aiming to enable users to raise their concerns about the health services provided to them, and to hold health providers accountable for actions and decisions related to the health service provision. They also aim to facilitate health providers taking users' needs and expectations into account when providing care. At least three core elements are assumed to be involved: voice, enforceability and answerability. Voice includes mechanisms, formal and informal, through which people individually or collectively express their concerns and expectations, and demand accountability from power holders. Enforceability comprises the means available to sanction non-compliance, wrongdoing and/or not appropriately fulfilling the mandate. It entails the possibility of penalties or other consequences for failing to answer accountability claims. Answerability refers to the obligation for the power holder to provide information and justification about their actions (account) and the people's right to receive a response, including the feedback process and responsiveness. Responsiveness was defined as the extent to which a health provider demonstrates 'receptivity' to the ideas and concerns raised by citizens and to which he/she intends to or actually 'implements changes'

to the decision-making or management structure, culture, policies or practices, or 'changes behaviour' at the point of service. The supposition is that for social accountability in maternal health services to work, women need to express their concerns and have channels to provide feedback, and providers need to be open to user feedback and willing and able to change practices.

Research design

The research approach used in this thesis was the Interactive Learning and Action approach, as social accountability in maternal health services is a complex social phenomenon occurring in the interface between the community and the health services. The research was carried out at two sites deliberately selected as cases in two provinces in rural DRC. The study population included people involved in the social accountability process in maternal health services specifically; community members and health providers mainly selected using a purposive sampling strategy. Both qualitative and quantitative data collection approaches were used, such as documentary review, non-participative observations, semi-structured interviews, focus group discussions and structured interviews with questionnaires.

Semi-structured interviews and focus group discussions were transcribed *verbatim* in Lingala, one of main local languages, translated into French and checked by research team members. Observations were transcribed in notes. Both the observation notes and the transcripts were processed and coded using Atlas-ti 7 software. Deductive and inductive, thematic and content analysis approaches of data analysis were applied. Quantitative data from the household survey were recorded using Epi Info 7, and statistical analyses were performed using SPSS 23.0. The data were summarized using proportions for categorical variables and means with standard deviations for quantitative variables. The association between categorical variables was tested using Pearson's or likelihood-ratio chi-square test as well as Fisher's exact test when appropriate. Proportions and means were compared using the chi-square test and Student's t-test, respectively. Whenever a quantitative variable was not normally distributed, the median was used for summarizing the data, and a non-parametric test was used to compare the medians. A logistic prediction model was prepared using the backward procedure in order to identify factors associated with the dependent phenomenon. Independent variables included

socio-demographic, health and health service characteristics. The statistical significance was fixed at $p=0.05$. Data from the documentary review were processed and analysed with regard to their qualitative or quantitative nature according to the procedures described above. All participants provided informed consent prior to participation, and the thesis adhered to ethical principles according to Helsinki Declaration II.

The research process was roughly divided into four phases, the product of one phase serving as the input for the following phase. The four phases were: initiation and preparation; collection, exchange and integration; priority setting and planning; and project formulation and implementation. Following this process, the research was divided into two parts. The first part of the thesis, chapters 4 to 7, addresses the question of contexts, of existing social accountability mechanisms and of how women in the two research sites express their concerns about health services. The second part of the thesis addresses the question of what are the effects of social accountability in relation to health services responsiveness, considering the challenges raised in the first part.

Existing situation of social accountability mechanisms in the rural DRC health zones

Chapter 4 presents a multiple case study conducted to explore the context at the two sites and to analyse its influence on the operation of a social accountability mechanism. In Chapter 5, we explore how the concerns, expectations, questions and complaints of women are expressed and taken into account in maternal health provision in the two DRC rural health zones. The third study, reported in Chapter 6, examines using mixed methods to find additional factors that could influence the capacity of women to express their concerns about maternal health services, and Chapter 7 is a multiple case study that reflected on how the health committee, as the preeminent existing social accountability mechanism, functioned in regard to its role in social accountability.

The main findings regarding the existing situation of social accountability are presented according to the three core components of a social accountability mechanism. The first part of the thesis showed that voice mechanisms did not work in the DRC rural health zones and

that women in these locations did not complain about the healthcare provided, nor were they used to raising their concerns, complaints and expectations about the health services. This reluctance was related to the fear of reprisal and victimization due to power relations as they were not sure about the response of health providers to their action. Women also lacked knowledge about the available mechanisms for reporting concerns that guarantee anonymity and no reprisal, and have insufficient knowledge and information about their rights and entitlements, awareness of the health providers' mandate and the healthcare standards.

The research also found that several contextual factors affected the individual and community levels. These contextual factors concern age-related power, cultural norms as women in these settings grew up in a culture characterized by male dominance, the social value of childbirth and social considerations of health care, or the local customs to abstain from complaining.

The research showed that the health committee mentioned by participants did not collect the community voice nor provide feedback from the health services to the community. It is more often ignored by community members, resulting in insufficient community participation with regard to social accountability. The study also showed that some interventions used in health sectors such as a performance-based financing scheme and community health insurance scheme did not constitute appropriate voice mechanisms in the context of DRC.

In terms of enforceability, it was observed that the women considered themselves unable to influence the course of the functioning of the health service or the behaviour of the health providers, as they believed that they have less knowledge than the health providers, being laypersons unable to judge how healthcare should be provided. The study also revealed that women did not envision collective actions, as community activities involving the collective expression of opinion are considered political activities, and no powerful coalition has arisen to voice concerns despite the presence of numerous community groups.

The study revealed that the local context is quite constraining and provides little support for the operation of social accountability mechanisms, and the community was not involved in exerting enforceability capabilities in a performance-based financing and community health insurance scheme, all activities being done by external actors.

Community members seemed unable to imagine health providers as responsive as the latter are perceived as more likely to get angry and scold the complaining party for direct voicing. Additionally, the study showed that the health providers did not provide community members or their representatives with information about the health facility's performance.

This led to the conclusion that social accountability mechanisms were relatively non-functional in rural DRC and that the concerns, expectations, questions and complaints of women about the maternal health services were not formally taken into account by health providers as they were ignorant of them. This situation calls for a more appropriate social accountability mechanism that takes into account the challenges met in DRC rural health zones.

Design, implementation and effects of a social accountability intervention

The second part of the thesis addresses the question of what are the effects of social accountability in relation to health services responsiveness, considering the challenges raised in the first part. Chapter 8 describes a social accountability intervention. It was a participatory research study that reported on the process implemented in order to develop a social accountability initiative that might deal with all of the contextual challenges raised while answering the first sub-question. In this study, the Dialogue Model was applied to carry out an advisory process involving the beneficiaries, representatives of the health sector and local authorities in the two health zones. Chapter 9 describes the implementation and the evaluation of the experiment suggested by the participants in Chapter 8, using a community quasi-experimental study design, comprising a partial realist evaluation.

To address the challenge raised above with regard to social accountability, participants in the Dialogue Model suggested a social accountability experiment integrating six components: (i) involve community health workers and the health committee in collecting, transmitting and discussing community concerns about health services (voice); (ii) build the capacity of the community in terms of knowledge and information; (iii) involve community leaders through dialogue meetings with the health committee and health providers; (iv) discuss

with the health providers their attitude towards voice and the management of voice at the health facility level; (v) involve the health service supervisors in supporting community participation activities; and (vi) use other existing interventions, like a performance-based financing and community health insurance scheme. This experiment was implemented as a pilot intervention lasting 12 months.

Its evaluation showed that community health workers had collected a variety of community concerns ranging from individual health problems to health services problems, suggesting an increased community voice and monitoring of health services. It also showed that community health workers provided the community with health information, building community knowledge and awareness, and therefore contributing to improving their capability to detect health services problems and articulate their concerns. The collected concerns were transmitted to the health committee and discussed every month with health providers from the local health centres, who then had the opportunity to provide an explanation and set actions for dealing with community concerns, suggesting an improved answerability of the health providers. The community concerns, explanations and actions suggested were reported in the minutes of the meetings and transmitted to the health zone management team.

The improvement of the answerability of the health providers suggested an improvement in the community enforceability capacity which could be explained by the experimental setting, which combined the training of health providers to understand the role and mission of the health committee and that of health committee members in clear interface activities and with the support of other local stakeholders. The study also documented some changes implemented in health services related to concerns raised by community members, suggesting an improvement of the responsiveness of health providers to community concerns. The mechanisms triggered by this initiative for the facilitation of voice included the trust relationship among community members and community health workers and the health committee used as intermediaries, which gave confidence to the women and anchored community protection and support. The mechanisms triggered by this initiative for the facilitation of the health providers' answerability or health providers' responsiveness included the perception of the legitimacy of the health committee, financial incentives, social pressure and administrative accountability.

The experiment implemented a social accountability initiative and contributed to modifying the existing power relations between health provider and users. Five contextual conditions were found to be important: the existence of local community health workers and a health committee in place, known by the community, trained in their formal role, enacted in the national health policy, and the situation in which the health services are mainly funded through users' fees and supervised by a health zone management team.

Discussion and conclusion

In Chapter 10, the findings and lessons learned are discussed. Research findings supported the hypothesis of this study and showed that for social accountability in maternal health services to work, women need to express their concerns and have channels to provide feedback, and providers need to be open to user feedback and willing and able to change their practices. It also showed that community participation as currently practised has to be enhanced in order to improve the social accountability of health service providers. Specifically, the findings revealed that a social accountability initiative based on empowered community health workers and a strengthened health committee, associated with the training of health providers and the involvement of intermediaries, has the potential to increase the voice of the community, to improve the enforceability and to trigger the health providers' answerability. The result contributes to improving the responsiveness and performance of health providers.

These findings suggest the need to reorganize and strengthen the current community participation process, e.g. community-centred activities, to facilitate indirect voice mechanisms, to coordinate a social accountability initiative by combining several components, and the importance of involving the health providers in the process.

Further research should examine the effect of the social accountability due to improved community participation on improving the health service uptake, health literacy and empowerment of the community members.